ten that they must bow to the wishes of the primary care provider. Technology that specialists have become accustomed to using may be unavailable if a primary care provider deems it too expensive. Or a gatekeeper may make arbitrary judgments about the number of visits that a patient can make to a specialist. Specialists not used to second guessing from less knowledgeable colleagues may find this most distressing emotionally.

Managed care appears about to become a major player in the future of health care in the United States. The Clinton Administration suggests that this will become the major if not the only option. Physicians who are certain that this is a type of health care they will not practice will seek a viable alternative. But whatever the outcome, the face of American medicine, its art, and perhaps its soul, will likely be changed forever.

Responses

Defending the Art

CONTEMPLATING THE FUTURE of medical care is similar to staring into a foggy forest from which loud sounds emanate. We know there are powerful forces therein, but we cannot discern exactly whether they will oppose—or possibly help—us.

Virtually every scenario for health care reform in the United States is based on variations of managed care, whether health maintenance organizations (HMOs), preferred provider organizations, or independent practice associations. Soon independent medical practitioners will be museum pieces.

How will such practice arrangements affect the "art" of medicine? If the design and implementation of future health care plans are left to politicians, insurance company gurus, and the occupants of corporate boardrooms, the result will indeed be grim. A colleague recently told me of his experience with an HMO that required that he see a patient every 12 minutes. In my own state, a government-designed universal access plan would mandate seeing a large number of patients at capitation rates set so low as to preclude many clinical services.

Politicians and business directors view patients as differing little from small appliances, capable of being rapidly processed and shuffled, if need be, from one "provider" to another, possibly by way of a "gatekeeper." Any notion of medicine having an artful dimension is foreign to such health care reformers. They view medicine merely as a branch of engineering.

Before proceeding further, I offer my own definition of the art of medicine. This is the dimension of compassion and soulfulness of our clinical profession. It is our artfulness as clinicians that allows us to step beyond scientific observation and therapy to perceive the hurt or longing in our patients. Practice of the art requires time, patience, and privacy. The process cannot be rushed; a time clock is its enemy. The art allows us to lend encouragement in a difficult recovery process or to ease the travails of a hopeless illness. The art of medicine is our walk with each of our patients through the valley of the shadow.

For physicians so inclined, clinical practice is the career for which no substitute can be imagined. The art of medicine is an inseparable component of this professional life. In personal experiences with physicians in a highly structured British National Health Service, I have seen and experienced the art of medicine practiced undiminished. Similarly, in the Army Medical Corps, I have seen dedicated physicians bring the art of medicine into dispensaries, stockades, and emergency wards. Tired medical residents repeatedly show me their stamina by never relinquishing the art, no matter how late the hour or how disheveled the patient.

By their nature most physicians will insist on practicing the art as well as the science of medicine whatever the clinical setting. The ease with which this is accomplished requires wisdom at every stage of design, planning, and administration of health care plans. Reimbursement and practice space may be negotiable. The proper practice of the art of medicine is not. An early colonial American flag pictured a serpent and the motto "Don't tread on me." Quite possibly the serpent from our own caduceus may need to be similarly used to warn those organizers of medical care who would seek to deny physicians the privilege and obligation to practice humanely and thus artfully.

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Physicians' Responsibility Under Health Care Reform

MARVIN AUERBACK, MD, asks if managed care will change the art and soul of medicine? The answer is, "not necessarily."

The art and soul of medicine have been threatened before. For example, a prominent physician wrote, "The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine—or, to put it more bluntly, they are too 'scientific' and do not know how to take care of patients." This quotation is from Francis Peabody's famous essay, "The Care of the Patient," published in 1930.[1] We can take some solace from the realization that concerns over the art and soul of medicine are not unique to our time.

Today, the engine of change is not science but cost containment. It is a pervasive part of our everyday life and will be more so in our future. The Clinton reform proposals, for instance, would bring the rate of health care cost increases down to the level of increase of the gross national product by 1998 and hold it there. Assuming, for the sake of discussion, that the coming health care legislation embodies this intent, then physicians and society will be operating under a new constraint—a fixed

budget. New treatments, newly discovered needs, even new diseases can no longer be attacked by increasing the share of resources allocated to health care. More resources for one item can be developed only by reducing the resources spent on other items. Since the dollars available through health alliances will be constrained (rationed), care may also be constrained (rationed) unless the system becomes more efficient.

Under a fixed budget, the amount of health care available to the population becomes a direct function of the efficiency and effectiveness of the health care delivery system—how much bang is available from each limited buck. Ineffective delivery systems mean more waste and consequently less care. Physicians, as well as hospitals and others in the health care field, will now have a direct responsibility to society to organize systems to provide the best and most efficient care this fixed budget will allow. Physicians must accept the responsibility to be active participants in the design and management of these systems, rather than leave this to those with less understanding of health care delivery. Physicians must also show that they are a profession interested in the well-being of all Americans, as well as their own patients, and that they can do a better job under the constraints of fixed resources than bureaucrats, politicians, and other experts.

If physicians passively participate in systems in which they simply accept fees, or even negotiate fees, but accept no responsibility for making the system work, they will lose control over their practices. The payer—be it an insurance company or a single-payer government scheme—that takes the risks for access, costs, and quality must protect itself against these risks through micromanagement of physicians' practices. If, on the other hand, physicians accept responsibility and risks, control of the delivery system should lie with them as it does in some programs today.

I would say to Dr Auerback that if physicians manage managed care, the art and soul of medicine have a better chance of being preserved than if that management is turned over to others, regardless of how well-intentioned the others may be. The amount of art and soul that can be built into these systems will depend on the values of the physicians, the benefit to patients of these values, the degree of influence physicians have on the system, and the ability of the system to free up resources to support these desirable practices.

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REFERENCE

1. Peabody FW: Doctor and Patient. New York, NY, Macmillan, 1930, pp 27-57

Who Will Manage Patient Care?

MARVIN AUERBACK, MD, provides a cogent argument to support his conclusion that "the face of American medicine, its art, and perhaps its soul, will likely be changed forever." Although there are many reasons for the changes, few practicing physicians would deny that managed care is a major cause of the alterations in health care delivery and practice styles outlined by Dr Auerback. Few would also deny that major reform is needed.

Costs that are out of control—rapidly approaching 14% of our gross national product—and limited and unequal access to health care are problems that trickle down to shrink the pocketbook of all Americans and the quality of life of many. So the question we must ask is not should we fix the health care system, but how? And can we do it without threatening, perhaps destroying, the physician-patient relationship, which is so vital to the well-being of patients? Managed care has yet to provide an answer to either question.

Managed care systems are not homogeneous, but they are all based on the premise that medicine is and should be a business. This premise threatens the mutual confidence and trust between patients and physicians, both essential ingredients of successful patient care. This premise and the operational rules it requires threaten the autonomy of physicians as they make even minor decisions in day-to-day patient care and, more important, the autonomy of sick patients as they struggle to decide their own fate.

"Case managers" play an important role in managed care systems. They are seldom physicians, they never see patients, and they have no responsibility for the welfare of patients. They have a responsibility to their employer: the managed care plan. Their job is to save money for their employer by micromanaging physicians' decisions and, in turn, patients' illnesses. Not long ago I admitted a patient to hospital for placement of a Tenckhoff peritoneal catheter for permanent dialysis. Sometimes we can admit patients for this procedure and send them home in the evening. Sometimes it is in their interest to stay overnight. In this instance the patient had more pain than usual, along with severe vomiting, and we kept her an extra night. I received a call from a case manager at the patient's insurance company saying that he was "disallowing" the extra day's stay. I asked the person if he knew what a Tenckhoff catheter was, if he had seen patients with them, if he knew the possible complications of catheter placement, or if he had ever seen a patient with end-stage renal disease, let alone cared for one. The answer to all of the questions was "no." Not once in our conversation did he ask whether or not the patient benefited from the extra day in the hospital or whether or not she had recovered from her pain and vomiting.

The emphasis on the bottom line is placing pressure on physicians to act more like businessmen and businesswomen and less like patient advocates. Terms like competition and marketing are becoming required vernacular. We are being asked, indeed forced, to make bedside decisions based not on what is best for our patients, but on what is best for insurance companies and managed health care plans.

The practice of medicine is not in the most basic sense a business. Our job is not to sell goods or services, whether patients need them or not; nor should we be expected to make decisions about patient care based on profit mo-